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AUTHOR.

TYPICAL

UTERUS-BICORNIS:

LIVING SEVEN MONTHS CHILD EXPELLED FROM LEFT HORN.—LAPAROTOMY FOR PAROVARIAN CYST.—UTERUS-BICORNIS THEN DISCOVERED. RECOVERY.

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UNIQUE CASE OF UTERUS-BICORNIS.

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Pregnancy in the Left Horn.—At the end of the Twelfth Week from Date of Conception, Alarming Hæmorrhage per Vaginam set in.—Tumor apparent at the Left Hypogastrium.—Extra-Uterine Pregnancy strongly suspected.—Expectant Treatment.—Three and a half Months thereafter a Living Child was Born.—Four and a half Months following, Laparotomy Performed for Well Defined Swelling in the Left Ovarian Region.—Cyst, Size of Tamarind Orange, Enucleated from the Parovarium; Uterus Bicornis discovered.—Patient leaves Hospital Apparently Well on the Seventeenth Day.—Probable Pregnancy Twenty Days Later.

CONSERVATISM VS. LAPAROTOMY.—SUMMARY OF REPORTS OF OPERATIONS AND RESULTS IN SIMILARLY OBSCURE CASES.

In the month of July last I received a message to visit Mrs. S., whose interesting case is the subject of this communication. The members of the household present were in great trepidation over a sudden and profuse hæmorrhage from the patient, per vaginam. This was her first pregnancy. Physical proportions and constitutional health excellent. German parentage. Mar-

ried but a little over a year, at the age of fifteen years. The husband at the time was absent in a distant State, and this circumstance only tended to intensify the excitement of the occasion. The mattress and bed clothing beneath the patient were saturated with blood. The heart's action was rather feeble;

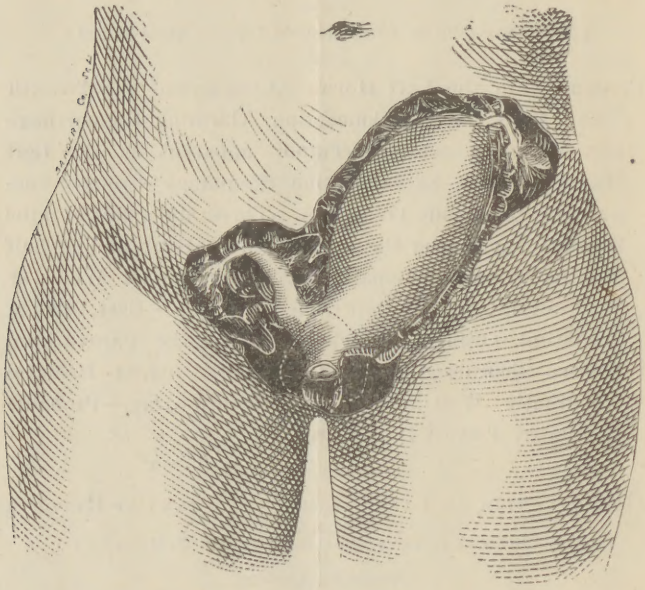

FIG. 1.

there were no abdominal pains. Hæmorrhage had ceased. The os was rather soft but not yielding or dilated. A tumor was plainly visible in the left side. Area of dulness, extent of which as nearly as I can outline it, is shown by the accompanying zinc etching. (Fig. 1.)

My mind was strongly impressed with the belief,

that I had to deal with an ectopic pregnancy. It was true there had been hæmorrhage per vaginam, which seemed now to be completely arrested; yet here was a tumor, following immediately upon the sudden flooding ~~hæmorrhage~~, and the tumor appeared, so far as the natural anatomical landmarks indicated, to be outside of the uterus, and in a direction parallel with Poupart's ligament. Dulness was absent in the median line.

I sat by the patient's bed-side, perhaps an hour; and as her condition improved during this period of time, I determined to treat the case expectantly. The sequel proves the wisdom of this course.

I was not again called to see this patient until October 20, being about three months after the visit to which the above has reference. The tumor, in the left side, had increased considerably in size. Its upper portion had reached the level of the umbilicus. The os was soft and now dilated. The patient complained of frequently recurring pains in the abdomen. No hæmorrhage. She stated she had been confined to bed for four days, suffering much in consequence of the uneasiness in the region of the tumor, and to such a degree as to deprive her of rest and sleep.

After the lapse of about three hours, during which time she was given chloroform, by inhalation, at intervals, a living child, weighing three and a half pounds, was expelled through the natural passages. There was no unusual flooding.

Besides the deformity of its legs and feet, the child was very small and puny. After thirty-two hours it expired. The cut, Fig. 2, fairly illustrates the positions of the feet and legs at the time of its birth.

The patient had regained much of her former physi-

cal weight and strength, when, during the early part of the month of February, she consulted me for dysmenor-

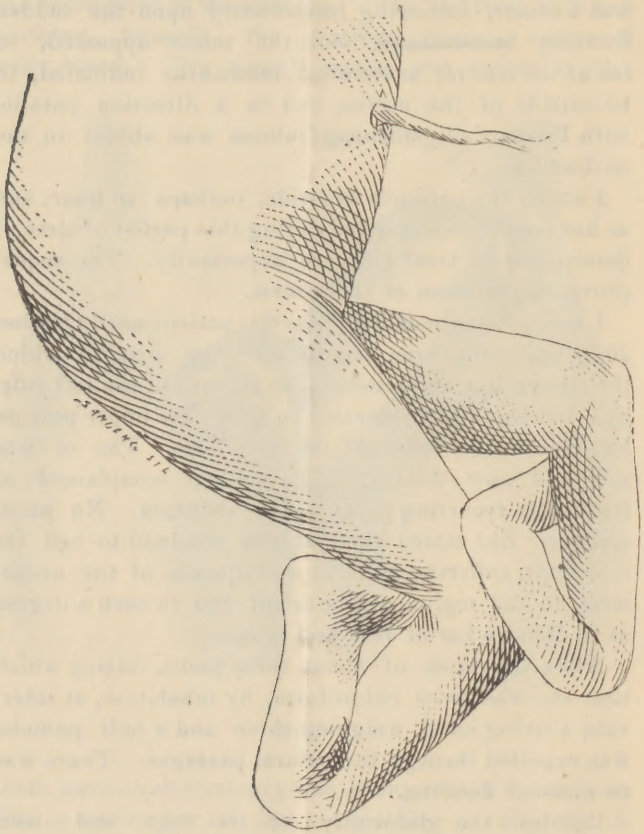

FIG. 2.

rhœa and almost constant pain in the left side, which increased in severity at each recurring menstrual period.

Upon examination a well defined swelling was found in the left ovarian region. After observing the case for about thirty days, on March 1st, I performed laparotomy, and removed a small cyst from the parovarium; and at the same time discovered the uterus to be bicornate; which is well illustrated by the accompanying zinc etching. (Fig. 3.)

The round body, outlined by the shading underneath the left tube, represents the cyst which I removed.

Dr. A. C. Robinson, of this city, was present, and made a very careful examination of the uterus through the abdominal incision.

The patient returned home on the eighteenth day, having made a rapid recovery. During convalescence she menstruated, and without the slightest pain. Within the next twenty days, after leaving the hospital, her husband reported that his wife was probably again pregnant.

The specially instructive features of the case are: 1st, the phenomena presented at my first visit, as given above; and 2d, the solution of the problem, that one horn of a typical bicornate uterus is capable of expelling a living child.

Cases *similar* to the above are narrated by men of large experience, and possessed of great sagacity and wise judgment. The principles of manipulation and treatment pursued by them, considered in connection with the final results, are on record, for adoption, modification or rejection by those to whom the responsibility of their like may be committed.

By a diligent search I have failed to find a *like* case on record. The element of "*expulsion*" renders it altogether unique; pertaining to which there is no literature and, consequently, no rule for guidance; but the

happy results of the course pursued demonstrates that that was the only one authorized, and must, therefore, become the precedent in all *like* cases in future.

Greig Smith, in his excellent treatise on "Abdominal Surgery," does not record a single case, and in the other now celebrated English work, which has helped so much to dignify gynæcological practice above the mere use of a sponge tent and a pledget of cotton, Mr. Tait speaks of but two cases, which present any resemblance whatever to the one just reported; and both of these described by him were published originally by Sir James Y. Simpson, some twenty-five years ago. Death, in both instances, was the result of the pregnancy in the left uterine horn. In one case the horn ruptured and the fœtus escaped into the cavity of the peritoneum;in the other the fœtus was retained in the left horn after the full period of utero-gestation, at which time severe labor set in and upon examination the os was found low down in the vagina. There was an enlargement of the abdomen extending a little to the left side, and nearly of the same size and shape as a uterus containing a fœtus at the full period of utero-gestation. The fœtal heart was easily heard, and the motions of the child were strong. The pains were very severe and complicated with convulsions for a whole day, in spite of a free use of chloroform, which only modified them. The pains continued for several days, and then the patient began to go about as usual, to the astonishment of her friends and neighbors. The enlargement of the abdomen became gradually less, so that at the time of her death (which took place six months after the date of the supposed labor) it was not more than one-third of its size when first seen. The organs, including the empty uterus and appendages, were carefully removed at a post-mortem

examination. The most prominent peculiarity found was a large irregular ovoid sac measuring about twenty-seven inches in its greatest circumference. The sac contained a male fœtus apparently about the full time, attached by a funis, one foot in length to a shriveled placenta, which in turn, was connected to the inner surface of the sac.

In these two cases conservatism was perhaps not the best course to pursue. On the other hand the more active measures have been adopted in several cases of pregnancy in bicornate uteri, although the real condition was not known, in either case, until disclosed by the operation.

Mundé reports an exceedingly instructive case in which a laparotomy was made for a suspected extra-uterine pregnancy. The woman had had one child several months before she placed herself under his care at the Mt. Sinai Hospital, in May, 1889. She had last menstruated four months before entering the hospital. The usual signs of pregnancy were present. A tumor of the size of two fists extended over toward the right side. A small mass could be felt projecting from the left side of the tumor, which he took to be the fundus of the uterus. He felt so sure of this that he introduced a sound into it, which entered barely three inches to the left. The mass on the right was elastic, but had not the feel of the pregnant uterus, and did not contract under examination. The woman had had a bloody discharge at intervals, and pieces of membrane were said to have been passed. She had had much pain in the tumor on the right side for at least a month, and so severe that she was induced to consult a physician. In the light of these conditions, Mundé unhesitatingly diagnosed it a case of tubal pregnancy. Fearing rupture, he at once

obtained the consent of the patient and her friends to an operation, and did laparotomy two days after he first saw her.

He was much surprised, on passing his hand into the abdominal cavity, to find that the peculiar irregularity of the tumor had disappeared, and that nothing could be felt except what seemed to be the normal pregnant uterus. He was rather nonplused; but the sound being passed again by his assistant, it went to the left side to the same depth it had entered before. He was now convinced he had an interstitial pregnancy to deal with, which condition he thought was quite as dangerous as the tubal pregnancy he had expected to find. He therefore decided to remove the amniotic fluid by aspiration, draw the uterus out of the abdominal cavity, open it, remove the ovum, and sew the horn of the uterus to the abdominal wound. At the first attempt at aspiration he struck the placenta (as the specimen afterward proved). Two more aspirations were made,and about one-half the amniotic fluid was removed. Not to prolong the operation, he lifted the uterus out of the abdominal cavity, when it was observed to be apparently normal in outline. The sound being passed again it went to the *right* to the very point where he had aspirated. Then the assistant, who passed the sound, said that he felt the septum of a two-horned uterus; and that is what the deformity proved to be.

The uterus was returned, the abdominal cavity closed, and, as expected, the patient miscarried that night. The specimen showed a large blood clot at the surface of the placenta where he had aspirated. The temperature did not rise above the normal, and the woman made a rapid recovery. Subsequent examination with two

sounds confirmed the presence of the uterine septum.

The cervix was lacerated on the left side, which shows that the previous pregnancy was on that side; this fact, in conjunction with the more or less constant pain in the pregnant right horn (which in a normally developed uterus would scarcely be present), led him to believe that the right horn was in a state of rudimentary development and would soon have burst.

He did not see how he could have made the diagnosis in the case unless he had accidentally passed the sound into the dilated pregnant right horn. He therefore concluded that the diagnosis of tubal pregnancy could not be made with as much certainty as is supposed. Fortunately this case turned out well, except that the fœtus was lost.

VanderVeer has collected and recorded, including his own, sixty-eight cases, in all, of "Concealed Pregnancy," in each of which the result of the laparotony revealed an error in diagnosis. Five of the cases, including the one just referred to, were found to be pregnancy in bicornate uteri. In one case the diagnosis before the operation was fibro-myxoma of the uterus; in two the operations were simply exploratory, and in the other case the diagnosis was extra-uterine pregnancy. In two cases the pregnancy had occurred in the right horn of the bicornated uteri; one was interstitial and the other in one horn, the particular side not stated. Four of the women recovered. Whether or not pregnancy again occurred in either of these cases is not a matter of record, but their subsequent history, if known, would be exceedingly interesting. It is my intention to keep careful record of the progress of the case reported, and at some future time give it publication.

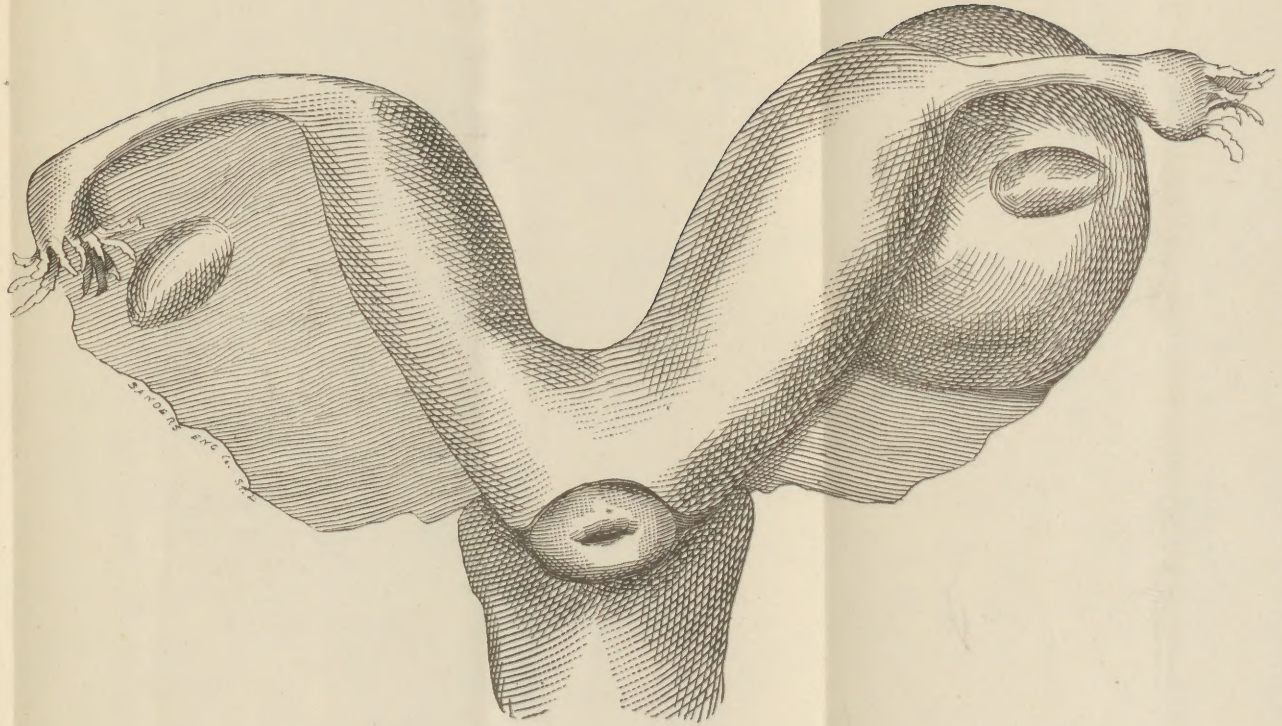

Fig. 3.